is the one condemning and prohibiting determination of the sex of the unborn child solely for the purpose of killing the female foetus. This issue also highlights the total lack of concern for ethics not only on the part of the authorities whose duty it is to implement the law, but also of the medical councils and, of course, of the medical profession and its many august bodies—none of which raised even a whimper against the unethical and illegal practice. It was left to the judiciary to pass strictures and demand action.

There are several other issues crying for public debate and the formulation, implementation of ethical policies: criteria for availing of expensive tertiary care (including intensive care) in public hospitals, streamlining the transfer of seriously ill patients from a primary healthcare unit to an appropriate tertiary care facility, the right of a terminally ill person in unmitigated suffering to die, advance directives against resuscitation and heroic therapeutic measures, gene manipulation and therapy…. The medical profession has been rightly condemned for taking too much decision-making power into its own hands, to the detriment of the common people. The making of public health policy has been dominated jointly by the medical profession and politicians. If we are to ensure ethical consideration in the formulation and implementation of such policies, it is essential for the people to be involved in these processes. Since the public is an amorphous mass, the responsibility devolves on the intelligentsia, especially those with a social conscience and those acting as our watchdogs—the media. This responsibility cannot be discharged in a ‘one-time’ exercise but must form a continuing and enduring effort.

REFERENCE


ISSUES IN MEDICAL ETHICS carries, in its volumes, several essays, discussions and reports on relevant topics. The interested reader may wish to refer to them.

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Maternal Mortality in India: No room for complacency

It is fifteen years now since the launching of the International Safe Motherhood Initiative in 1987, and ten years since the Government of India’s Child Survival and Safe Motherhood Programme was initiated. Tragically, however, maternity continues to claim the lives of millions of Indian women year after year. According to the National Family Health Survey (NFHS)-II, the maternal mortality ratio in the country is 540 per 100,000 live-births (1998–99), showing no decline from the levels reported by NFHS-I in 1992–93. These ratios are among the highest in the world.

It is indeed baffling that in a country that boasts of medical expertise comparable to the best in the world, women in the prime of their lives are allowed to die during the course of bringing forth new lives. Unlike rare or newly emerging health problems and conditions about which little is known, and for which there are no known cures, we have the benefit of more than a century of accumulated knowledge about the causes of maternal death and what needs to be done to avert them. Why then does this state of affairs continue?

One of the major reasons is our failure to learn from the experiences and mistakes of the past fifteen years of implementing maternal health programmes. For example,
a large number of studies on maternal mortality and morbidity in India and elsewhere continue to assert that 'ignorance' underlies the high proportion of home deliveries by untrained birth attendants; that women are dying because they are having too many children, and lowering fertility levels would solve the problem; that universal institutional delivery is the magic solution that would bring down maternal mortality ratios dramatically, and so on. Yet, experiences with implementing interventions to prevent maternal deaths belie many of these assumptions.

Key lessons
The following are some lessons that can be gleaned from studies and programme experiences from many parts of the world:

• The first and perhaps the most important lesson is that we need to examine the tangled web of causes underlying maternal deaths from the perspective of those most affected—the women themselves. We need to understand the gender power inequalities, including gender-based violence and women's lack of decision-making power which makes it difficult for many women to prevent high risk or unplanned pregnancies, adopt healthy behaviour when pregnant, ensure they have trained attendance at delivery, seek healthcare when complications arise, or receive appropriate care when they reach a health facility after crossing many a hurdle.¹

• Lowering fertility levels through the use of family planning methods need not reduce maternal mortality ratios. It is true that fewer women may die in terms of absolute numbers because fewer of them get pregnant and are thus not exposed to the ‘risk’ of maternal death. However, contraception does not reduce the risk of complications and death once a woman gets pregnant.

• Despite the availability of contraception, induced abortion will continue to be a need. Any serious attempt at preventing maternal deaths will have to address the issue of making safe abortions available, accessible and affordable.

• Women ‘choose’ home deliveries because, more often than not, they have little else to choose from. Few primary health centres are equipped to attend to deliveries, and access to referral hospitals is difficult. Moreover, trained birth attendants provide domiciliary care at affordable costs, without offending the women’s self-respect.

• One-shot training of traditional birth attendants (TBAs) and abandoning them to work in isolation without supervision and referral support from a well-functioning health system was doomed to fail from the outset.² To then abandon the entire strategy as having failed to make an impact on levels of maternal mortality is to further compound this error. TBAs have a role to play, especially in settings where it will be decades before universal access to institutional deliveries becomes a reality. What is needed is recognition of their specific strengths and skills, and a clear definition of their roles and functions as an integral part of the maternal health services mechanism.

• The limited procedures carried out in the name of antenatal care in the public health system have had little or no impact in lowering maternal mortality and morbidity. This does not mean that antenatal care is not important for individual women, especially when followed up with referral care. What we now know is that antenatal care and identifying ‘high risk’ pregnancies does not help predict which women will develop complications and which women will not. To have a public health impact, we need to develop strategies that will start from the premise that any woman can develop complications any time during or after the termination of a pregnancy.³

• A greater proportion of maternal deaths—an estimated 60%—occur during the postpartum period rather than during pregnancy or delivery. And yet, postnatal care is the weakest component of the maternal healthcare package, whether the woman delivers at home or in a health facility.⁴

• In the present context of resource crunches and cuts in health budgets, emergency
obstetric care may be rendered ineffective even where facilities exist, because of the poor functioning of the health system as a whole. Supplies have to be available, the referral chain has to work, the health providers well trained and motivated, the facility adequately resourced. It is not possible to make a health system functional just to deliver better maternal healthcare, when it is dysfunctional overall.5,6

- Institutional deliveries may not help prevent maternal deaths, but may lead to the sad situation where women die in institutions rather than at home, because they arrive too late to be saved, or because their health status was so poor to begin with. Health services at the primary level have not been improved sufficiently to safeguard the lives of women till they reach a referral facility. Recent Indian studies have reported a greater proportion of maternal deaths from anaemia than before, and from indirect causes such as malaria and viral hepatitis owing to the poor functioning of the public health infrastructure, among others.7

- A significant proportion of maternal deaths in health facilities are from ‘avoidable’ causes such as delays in starting treatment, lack of drugs, lack of blood, and wrong diagnosis or treatment.8 Experiences of the ‘Preventing maternal mortality network’ in Africa in tackling these issues have shown that where the medical profession has the commitment and the will to tackle health system-related challenges, it can make a huge difference to preventing maternal deaths. The setting up of a system of accountability through annual ‘Confidential enquiries on maternal deaths’ is another mechanism that has helped enforce accountability and reduce maternal mortality in many countries; for example, in the UK and Malaysia.

Our programme strategies need to draw on these lessons and begin afresh with bolder initiatives. Rather than going our separate ways because we believe we alone were doing the right thing, it is time to get our act together and forge partnerships. All potential stakeholders need to come together—health professionals, researchers, policymakers, donors, women, community leaders, non-governmental organizations and women’s health advocates. We need to recognize that simultaneous efforts are needed on all fronts. At the grassroots, both to create community awareness and promote women’s ability to seek services. This would in turn create a demand on services. However, if the health services are not organized to meet this enhanced demand, there would be a stalemate. The health sector has to simultaneously gear up to rise to the challenge through improving the clinical skills and managerial capabilities of service providers. Leadership and commitment on the part of health professionals is a crucial element in bringing pressure on policymakers to provide the resources and support necessary to improve maternal health services. Researchers need to get involved in relevant research that would help identify priorities, plan interventions and assess their impact.

We cannot afford to be complacent any longer. It is time to get angry about the tragic and unnecessary loss of women’s lives. It is time to act, wherever we are, in whatever way we can.

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